MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5656 **CERTIFICATE OF DEATH** 05644

1

(M)

1. **PLACE OF DEATH**
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE Md — b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace
d. STREET ADDRESS 613 S Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Russell — Middle Samuel — Last Abbott

4. DATE OF DEATH: Month May — Day 9 — Year 1961

5. SEX: Male — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: June 16 - 1907 — 9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

(I)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed — 10b. KIND OF BUSINESS OR INDUSTRY: Abbott Bros — 11. BIRTHPLACE (County & State, or foreign country): Md — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin J. Abbott ? — 14. MOTHER'S MAIDEN NAME: Catherine MC Nulty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): Unknown — 16. SOCIAL SECURITY NO.: Unknown — 17. INFORMANT: Hazel J. Abbott — Address: 613 S. Washington Havre de Grace Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Carcinomatosis	1 Month
DUE TO (b)	Carcinoma of Larynx	2 1/2 years
DUE TO (c)		

161X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..., to ..... 19...., that (I) (we) last saw the deceased alive on ..... 19....., and that death occured at 9:45 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Edward L. Wardman M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) — 23b. DATE THEREOF: 5/12/61 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. Carr — 23d. LOCATION (City, town or county) (State): Havre de Grace Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Pennington Bros. — ADDRESS: Havre de Grace Md. — 25a. REC'D BY REGISTRAR: MAY 11 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G288 6/7/61 iwk

CERTIFICATE OF DEATH

5657

Reg. Dist. No. 05645

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford County Alms House

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): X Pylesville
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Hobart; Middle; Last Bay
4. DATE OF DEATH: Month May; Day 29; Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Nov. 21, 1896
9. AGE (In years last birthday): 65 64 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Employee
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME: Oliver Alexander Bay
14. MOTHER'S MAIDEN NAME: Fannie Caloway Smithson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-12-5238
17. INFORMANT: Address: Mrs. Ralph Manifold, Stewartstown, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary sclerosis

DUE TO (c): Chr. Cardio-vascular Disease — ??

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m.; Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 2, 19 61, to May, 29, 19 61, that I last saw the deceased alive on May 25, 19 61, and that death occurred at 12:30PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Md. — DATE SIGNED: May 29, 1961

PHYSICIAN'S NAME (Type): Willard P. Hudson M.D. — Forest Hill, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 1, 1961
22c. NAME OF CEMETERY OR CREMATORY: Holy Cross
22d. LOCATION (City, town, or county) (State): Rocks, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John R. Harbaugh — ADDRESS: Delta, Penna.
24a. REC'D BY REGISTRAR DATE: JUN 5 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5653 — 05646

1. PLACE OF DEATH

a. COUNTY: HARFORD — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE

c. LENGTH OF STAY IN 1b: 21 hrs. 24 min

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE: MARYLAND — b. COUNTY: HARFORD

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE

d. STREET ADDRESS: 102 SENECA ST.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
WILLIAM	CLAUDE	BOWMAN	MAY	22	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W		MAY 22, 1961			21 / 24

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: BILL E. BOWMAN

14. MOTHER'S MAIDEN NAME: NATALIE LEISHMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Hosp Records — Address: Havre de Grace Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral anoxia	1 dy
DUE TO (b)	Pneumonitis suboicity	1 dy
DUE TO (c)	Prematurity	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — 763.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on .....19....., and that death occured at 10:21 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Irvin L. Wachsman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/24/61

22c. PHYSICIAN'S NAME (Type): IRVIN L. WACHSMAN M.D

22d. ADDRESS: 107 S. UNION AVE. HAVRE de GRACE MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 5/24/61

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill

23d. LOCATION (City, town or county) (State): Havre de Grace Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington Bros. — ADDRESS: Havre de Grace Md

25a. REC'D BY REGISTRAR DATE: MAY 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5659

Reg. Dist. No. 05647

M

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
c. LENGTH OF STAY IN 1b: 32 yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bush Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
d. STREET ADDRESS: Bush Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

I

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Thomas	Brayton		May	3	1961

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	C	WIDOWED [X]	April 17, 1861	100 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Owner	USA Va	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	none	Elizabeth Harris Baltimore, Md.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: —

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse lost. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work [ ] Not while at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and find that death resulted from: Naturol causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: Gerald E Palmer M.D.
EXAMINER'S NAME (Type): Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: Bel Air, Md 5-3-61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	May, 7, 1961	John Wesley	Abingdon, Harford, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Howard K. Mc Comas & Son Howard K. McComas Jr.	Abingdon, Maryland.	MAY 9 '61	Arthur L. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5660

CERTIFICATE OF DEATH

11564S

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Harford Memorial

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 116 Beaver St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles — Middle: J. — Last: Callahan

4. DATE OF DEATH: Month: 5 — Day: 29 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: 1/25/1901

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles J. Callahan

14. MOTHER'S MAIDEN NAME: Margaret Bodani

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Joshua Lusby — Address: 116 Beaver St. Havre de Grace Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Parotid Gland — INTERVAL BETWEEN ONSET AND DEATH: about 1 yr.
DUE TO
142.0
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1960 to May 1961, that (I) (we) last saw the deceased alive on 5-29-1961, and that death occured at 4:30 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Edward J. Simon M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-29-61

22c. PHYSICIAN'S NAME (Type): E. J. SIMON

22d. ADDRESS: HAVRE DE GRACE, MD

23a. (BURIAL) CREMATION, REMOVAL (Specify) — **23b. DATE THEREOF**: June 1, 1961 — **23c. NAME OF CEMETERY OR CREMATORY**: St. John Catholic — **23d. LOCATION** (City, town or county) (State): Long Green Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Pumphrey Bros, Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: JUN 5 '61 — **25b. REGISTRAR'S SIGNATURE**: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05649

1. PLACE OF DEATH — a. COUNTY: Harford 5661 — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 70 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace, Md.
d. STREET ADDRESS: 632 Ontario
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: Chapman — Last: Caponie

4. DATE OF DEATH: Month: 5 — Day: 29 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 3, 1890

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Post Office Dept.

11. BIRTHPLACE (County & State, or foreign country): Parsons Town Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Chapman Caponie

14. MOTHER'S MAIDEN NAME: Mary C. Flarity

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Laura Caponie — Address: 632 Ontario St. Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Diabetes Mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5-07, 19 54 to 5-29-, 19 61 that (I) (we) last saw the deceased alive on 5-29 19 61, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: A. Caponie M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. (BURIAL) CREMATION, REMOVAL (Specify) — 23b. DATE THEREOF: 6/2/61 — 23c. NAME OF CEMETERY OR CREMATORY: Angel Hill — 23d. LOCATION (City, town or county) (State): Havre de Grace Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Thomas J. Roy — ADDRESS: Havre de Grace Md.

25a. REC'D BY REGISTRAR DATE JUN 5 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5662

CERTIFICATE OF DEATH

Reg. Dist. No. 05650

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 3 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
d. STREET ADDRESS 140 St. John
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Hiram Middle: H. Last: Case

4. DATE OF DEATH Month: 5 Day: 12 Year: 19 61

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 1/12/1887

9. AGE (In years last birthday) 74 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman

10b. KIND OF BUSINESS OR INDUSTRY Advertising

11. BIRTHPLACE (State or foreign country) Havre de Grace Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Nelson B Case

14. MOTHER'S MAIDEN NAME Mary E Esley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT Hattie F. Case Address 624 W. James St., Lancaster Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO (b) Cardio Vascular disease
DUE TO (c)

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/6 19 59, to 6-12 19 61, that I last saw the deceased alive on 4-17 19 61, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE Arthur M M.D. ADDRESS (Street, city or town, state) Havre de Grace Md DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF 5/14/61

22c. NAME OF CEMETERY OR CREMATORY Angel Hill

22d. LOCATION (City, town, or county) (State) Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE Baumgartner & Son ADDRESS Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE MAY 18 '61

24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5663 — 65651

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
c. LENGTH OF STAY IN 1b: 30 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route #2 Box 300

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Street
d. STREET ADDRESS: Route #2 Box 300
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
John	H.	Ceris Sr.	5	1	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro		Oct. 1, 1896	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitor	Army Chemical Center	Harford County	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Benjamin Ceris	Hannah Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes WW I	220-01-5788	Mrs. Mary E. Ceris, Street, Md.	R-2 Box 300

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Uremia	
603X DUE TO (b)	Hypertensive Cardiovascular disease	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Renal Insufficiency	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.V.A.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/17, 1960 to 5/1, 1961, that (I) (we) last saw the deceased alive on 4/28 1961, and that death occured at 7:30 PM, from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
George T. Stansbury.			5/2/61
22c. PHYSICIAN'S NAME (Type) George T. Stansbury		22d. ADDRESS 569 Revolution St. Havre de Grace, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	5-6-61	Cedar Cemetery	Darlington, Harford Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Elmer C. Bullock, Havre de Grace Md.	556 Lewis St.	DATE MAY 3 '61	Arthur S. Kraas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5664

CERTIFICATE OF DEATH

05652

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 324 Superior, ST

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
d. STREET ADDRESS: 324 SUPERIOR, ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SAMUEL Middle GOLDSMITH Last CURRY

4. DATE OF DEATH: Month MAY Day 12 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 29 1892

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TELEPHONE REPAIRMAN

10b. KIND OF BUSINESS OR INDUSTRY: A.T.&T. RETIRED

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN SAMUEL CURRY

14. MOTHER'S MAIDEN NAME: MARGARET LEE WRIGHT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-05-7273

17. INFORMANT: Mrs. Lottie L. Curry — Address: 324 Superior ST Havre de Grace, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO
(b): Coronary Occlusion
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospitol) ottended the deceased from 5-12 1961, to 5-12 1961, that (I) (we) lost sow the deceosed olive an 5-12 1961, and that death occurred ot 7:15 P.M., from the causes and on the dote stoted above.

22a. SIGNATURE: Lowell Hirsch M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-13-61

22c. PHYSICIAN'S NAME (Type): DR. C. HIRSCH

22d. ADDRESS: 421 Congress Ave. Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 15 1961

23c. NAME OF CEMETERY OR CREMATORY: ROCK RUN CEM.

23d. LOCATION (City, town, or county): HARFORD (State): MD

24. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell ADDRESS: Havre de Grace, MD

25a. REC'D BY REGISTRAR: MAY 17 '61

25b. REGISTRAR'S SIGNATURE: Catherine L. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5665

CERTIFICATE OF DEATH

05653

1

(M)

(I)

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
d. STREET ADDRESS: R.D. 1 ~~Xxxxxxxxxx~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Augusta — Last: Deckman

4. DATE OF DEATH: Month: 5 — Day: 25 — Year: 1961.

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 24, 1878

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Xxxxxxxxxx~~ Housewife, Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John F. Finkernagel

14. MOTHER'S MAIDEN NAME: Amelia H. Oales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or defes of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Frances C. Preston, Aberdeen, Md. — Address: 627 Jennifer Lane

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Rt. Supracondylar Fracture — 5 days
DUE TO (c): Generalized Osteoporosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Dementia due to Cerebral Arteriosclerosis

733X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Dey, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/20, 19 61, to 5/25, 19 61, that (I) (~~was~~) last saw the deceased alive on 5/25 19 61, and that death occured at 7:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. H. Sadowsky M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: May 25, 1961

22c. PHYSICIAN'S NAME (Type): W. H. SADOWSKY

22d. ADDRESS: 504 Lewis St. Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/27/61

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cemetery

23d. LOCATION (City, town or county) (State): Havre de Grace, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — **ADDRESS**: Tarring Funeral Home Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: JUN 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5666

CERTIFICATE OF DEATH

05654

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Box 31 - Rural # 2

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: Box 31 - Rural # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martin — Middle: Gregory — Last: Jonathue

4. DATE OF DEATH: Month: ✓ — Day: 11 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/10/1896
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Govt. etc.
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bernard Jonathue
14. MOTHER'S MAIDEN NAME: Emma Use

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give wer or dates of service): War I
16. SOCIAL SECURITY NO.: 214-14-0747
17. INFORMANT: Gertrude K. Jonathue — Address: Rural # 2 - Box 31 - Aberdeen

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: One hr.
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertention — 1956
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March, 1938 to May, 1961, that (I) (we) last saw the deceased alive on May 7 1961, and that death occured at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Andre Weiss M.D.
ATTENDING PHYS. ✓ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 12, 1961
22c. PHYSICIAN'S NAME (Type): ANDRE WEISS M.D.
22d. ADDRESS: 114 W Bel Air Av. Aberdeen

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 15, 1961
23c. NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens, RD. Havre de Grace
23d. LOCATION (City, town or county) (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring - Aberdeen, Md.
ADDRESS: Tarring Funeral Home
25a. REC'D BY REGISTRAR DATE: MAY 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5667 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05655

Item 9 Film G288 5/29/61

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RD 4 Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Johnson's Mill Road

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 32 Belair
d. STREET ADDRESS: Johnson's Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Izetta — Middle: Rose — Last: Dowell

4. DATE OF DEATH: Month: May — Day: 22 — Year: 19 61

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 6 1907

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework at Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Allegheny Co. Md. USA

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Emory Burchew

14. MOTHER'S MAIDEN NAME: Laval Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mack Dowell — Address: Bel Air Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ Bel Air Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C Palmer M.D.
Address (Street, city, town, or county):
DATE SIGNED: 5-22-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 25, 1961
22c. NAME OF CEMETERY OR CREMATORY: Sparta M.C.
22d. LOCATION (City, town, or country) (State): Md.

23. FUNERAL DIRECTOR — ADDRESS: H. L. Bailey Darlington Md

24a. REC'D BY REGISTRAR DATE: MAY 25 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Hearne

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5668 — 05656

1 — M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Havre de Grace
d. STREET ADDRESS: 428 S. Union Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martin — Middle: P — Last: Foley

4. DATE OF DEATH: Month: 5 — Day: 1 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: 5/13/1904

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: Program pilot of Hand Van Lines Trucks

11. BIRTHPLACE (County & State, or foreign country): Md - Harford Co.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Martin P. Foley

14. MOTHER'S MAIDEN NAME: Ellen Koendess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis
DUE TO (b): Chronic Paralytic ileus
DUE TO (c): Dehydration

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 570.1

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Prolonged Diuretic Administration

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a.m. / p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11 AM May 1 1961 to 10 PM May 1 1961 that (I) (✓) last saw the deceased alive on May 1 19 61, and that death occured at 10 PM, from the causes and on the date stated above.

22a. SIGNATURE: J H Sadowsky M.D.

22b. DATE SIGNED: May 2, 1961

22c. PHYSICIAN'S NAME (Type)

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 504 Lewis St Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 5/4/61

23c. NAME OF CEMETERY OR CREMATORY: Mt. Erin

23d. LOCATION (City, town or county) (State): Havre de Grace Md

24 FUNERAL DIRECTOR'S SIGNATURE: Tommy Lee Tom — **ADDRESS**: Havre de Grace Md

25a. REC'D BY REGISTRAR DATE: MAY 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Travis

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5665 — 05657

1. **PLACE OF DEATH**
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitel, give street address): HARFORD MEMORIAL HOSP.

2. **USUAL RESIDENCE** (Where deceased lived, If institution, residence before admission)
a. STATE: MARYland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DARLington
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BABY GIRL — Middle — Last: HENRY

4. DATE OF DEATH: Month: MAY — Day: 8 — Year: 19 61

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-6-61

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days: 2 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEWBORN

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: JOSEPHINE SUTTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Josephine Sutton Darlington

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coarctation, Ductal of aorta — INTERVAL BETWEEN ONSET AND DEATH: at birth

DUE TO (b): Patent ductus arteriosus

DUE TO (c): CONGENITAL ANOMALY

7541

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Yeer: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from MAY 6, 19 61 to May 8, 1961, that (I) (~~was~~) last saw the deceased alive on May 8 19 61, and that death occured at 5 AM, from the causes and on the date stated above.

22a. SIGNATURE: Frank Wolbert M.D. — M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: MAY 9. 1961

22c. PHYSICIAN'S NAME (Type): FRANK WOLBERT MD

22d. ADDRESS: HAVRE DE GRACE MARYLAND

23a. BURIAL CREMATION REMOVAL (Specify): Cremation

23b. DATE THEREOF: May 8, 1961

23c. NAME OF CEMETERY OR CREMATORY: Harford Memorial Hospital

23d. LOCATION (City, town or county) (State): Have de Grace, Md

24 FUNERAL DIRECTOR'S SIGNATURE: Harry R Tilley — ADDRESS: administrator

25a. REC'D BY REGISTRAR DATE: MAY 31 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2071347XX2

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5670 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05658

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME SM 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Md
   b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
   d. STREET ADDRESS: Old Bay Farm
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Calvin — Middle: Hill — Last:

4. **DATE OF DEATH**: Month: May — Day: 8 — Year: 19 61

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Jan 29, 1961

9. AGE (If years last birthday): X yrs. — IF UNDER 1 YEAR: Months: 3 Days: 9 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: duPont

11. BIRTHPLACE (State or foreign country): Havre de Grace, Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Willis D. Hill

14. MOTHER'S MAIDEN NAME: Shirley Lee Gerald

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mr. Willis D. Hill — Address: Old Bay Farm Havre de Grace, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): BRONCHIAL PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH:

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county): Bel Air, Md.

DATE SIGNED: 5-8-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/10/61

22c. NAME OF CEMETERY OR CREMATORY: A.P.G. Cemetery

22d. LOCATION (City, town, or country) (State): Aberdeen Proving Ground, Md

23. FUNERAL DIRECTOR: Elmer E Bullock — ADDRESS: Havre de Grace, Md

24a. REC'D BY REGISTRAR — DATE: MAY 15

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

2-65019-2-XV-4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5671 — Reg. Dist. No. 10565

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Darlington
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-- Darlington
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Otis Henry Middle: Hunt Last: Hunt

4. DATE OF DEATH: Month: May Day: 4, Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 5, 1897

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Aberdeen P.G.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New Hampshire

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Henry otis Hunt

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 003-01-0647

17. INFORMANT: Mrs Gale Hunt — Address: Darlington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 20 min.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 414 X
(b) Rheumatic endocarditis and myocarditis(Chronic) — ??
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 2, 19 50, to May 1961, 19 ____ that I last saw the deceased alive on May 6, 1960, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Md. — DATE SIGNED: 5/5/61

PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): — 22b. DATE THEREOF: May 8, 1961 — 22c. NAME OF CEMETERY OR CREMATORY: Bel-Air Memorial at Harford — 22d. LOCATION (City, town, or county) (State): Co, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. S. Bailey — ADDRESS: Harlington, Md.

24a. REC'D BY REGISTRAR DATE: MAY 10 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5672

CERTIFICATE OF DEATH

Reg. Dist. No. 05661

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 99 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 217 N. Union Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bennett — Middle: Aquila — Last: Keen

4. DATE OF DEATH: Month: 5 — Day: 21 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/18/1862

9. AGE (In years last birthday): 99 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Waterman

11. BIRTHPLACE (State or foreign country): Aberdeen

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Aquila Keen

14. MOTHER'S MAIDEN NAME: Charlotte Johnson or Mary Joyner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Eden Keen — Address: 217 N. Union Ave., Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Insufficiency
DUE TO (b): age
DUE TO (c):

422.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 5/18/61, and that death occurred at _____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED

PHYSICIAN'S NAME (Type): [illegible] Havre de Grace Md

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 5/23/61

22c. NAME OF CEMETERY OR CREMATORY: Angel Hill

22d. LOCATION (City, town, or county) (State): Havre de Grace, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible] Havre de Grace Md

24a. REC'D BY REGISTRAR DATE: MAY 25 '61

24b. REGISTRAR'S SIGNATURE: Clinton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5673

CERTIFICATE OF DEATH

Reg. Dist. No. 05661

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Street
c. LENGTH OF STAY IN 1b: 76 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.#2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Street
d. STREET ADDRESS: R.D.#2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle HENRY — Last KOHLBUS

4. DATE OF DEATH: Month May — Day 23 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 3, 1885

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Kohlbus

14. MOTHER'S MAIDEN NAME: Elizabeth Nichols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-07-0294

17. INFORMANT: Mrs. Paul Iddings, Address Street, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ? ?

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): arteriosclerosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1, 1961, to May 22, 1961, that I last saw the deceased alive on May 22, 1961, and that death occurred at 4 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Hyson M.D. — ADDRESS (Street, city or town, state): Fawn Grove, Pa. — DATE SIGNED: 5/24/61

PHYSICIAN'S NAME (Type): Edward W. Hyson — Fawn Grove, Penna.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 25, 1961

22c. NAME OF CEMETERY OR CREMATORY: Emory

22d. LOCATION (City, town, or county) (State): Street, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Watkins — ADDRESS: Delta, Penna.

24a. REC'D BY REGISTRAR DATE: MAY 26 '61

24b. REGISTRAR'S SIGNATURE: Curtis L. Hayes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5674

CERTIFICATE OF DEATH

Reg. Dist. No. 05662

1. PLACE OF DEATH
a. COUNTY: Harford. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: JJ Mt. Royal Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: JJ Mt. Royal Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Middle: Claude Last: Krauss
4. DATE OF DEATH: Month: May Day: 8th Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/14/1901
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber, Self employed
10b. KIND OF BUSINESS OR INDUSTRY: Barber
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John Krauss
14. MOTHER'S MAIDEN NAME: Annie Suder
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-16-9442
17. INFORMANT: Velma Palmer Krauss Address: JJ Mt. Royal Ave Aberdeen Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Ventricular Fibrillation	Terminal
DUE TO	4-20.1	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Coronary Occlusion	5 minutes
DUE TO (c)	Coronary Arteriosclerosis	5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1953, 19__ to 5-8, 1961, that I last saw the deceased alive on May 8 - 1961, and that death occurred at 1:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter P. Rodman, M.D.
ADDRESS (Street, city or town, state): 8 Law St. Aberdeen, Md.
DATE SIGNED: 5-8-61
PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/11/61
22c. NAME OF CEMETERY OR CREMATORY: Babers Cemetery
22d. LOCATION (City, town, or county) (State): Aberdeen, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE: John G. Barring ADDRESS: Aberdeen, Maryland
24a. REC'D BY REGISTRAR DATE: MAY 12 '61
24b. REGISTRAR'S SIGNATURE: Clifton L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5675 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05664

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harford
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: N.C. — b. COUNTY: Iredell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Statesville
d. STREET ADDRESS: 1218 Broad Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: Ivey — Last: Lanier

4. DATE OF DEATH: Month: May — Day: 18 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 24, 1912

9. AGE (In years last birthday): 48 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): truck driver

10b. KIND OF BUSINESS OR INDUSTRY: trucking

11. BIRTHPLACE (State or foreign country): Iredell Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: M. M. Lanier

14. MOTHER'S MAIDEN NAME: Dora Matthews

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or defense service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

910.9

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fractures pelvis + femur

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): 2 Logs fell on him

20c. TIME OF INJURY: Hour 5 p.m. — Month, Day, Year: 5-12 1961

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rising Sun

20f. (City or town): Rising Sun (County): Cecil (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald E Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ Bel Air, Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gerald E Palmer M.D.

Address (Street, city, town, or county):

DATE SIGNED: 5-19-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 20, 1961

22c. NAME OF CEMETERY OR CREMATORY: Abilene Ch. of Christ Cem.

22d. LOCATION (City, town, or country): Iredell Co. (State): N.C.

23. FUNERAL DIRECTOR — ADDRESS: Pennington & Son, Havre de Grace Md.

24a. REC'D BY REGISTRAR DATE: MAY 22 '61

24b. REGISTRAR'S SIGNATURE: Cinthus S. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9 Film G288 5/29/61 iwk

5676

CERTIFICATE OF DEATH

Reg. Dist. No. 05667

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 40 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 701 Erie
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Bernadina Middle L. Last Leonardi

4. DATE OF DEATH: Month 5 Day 17 Year 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/28/1884

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: Joseph Levi

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Maria Kay Address: Revolution St Havre de Grace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ADENOCARCINOMA of BLADDER — INTERVAL BETWEEN ONSET AND DEATH: 6 month
181.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December, 1960, to 5-17, 1961, that I last saw the deceased alive on 5-17, 1961, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gunther D. Hirsch M.D. ADDRESS (Street, city or town, state): 421 CONGRESS AV. DATE SIGNED: 5-18-61

PHYSICIAN'S NAME (Type): GUNTHER D. HIRSCH HAVRE DE GRACE, MD.

22a. (BURIAL) CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 5/20/61

22c. NAME OF CEMETERY OR CREMATORY: Mt Erin

22d. LOCATION (City, town, or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington Bros ADDRESS: Havre de Grace Md

24a. REC'D BY REGISTRAR DATE: MAY 19 '61

24b. REGISTRAR'S SIGNATURE: Cathryn S. Kyne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3677 — 05665

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any information is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bel Air RT 2
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): her home Fountain Green

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Bel Air, Fountain Green
d. STREET ADDRESS: / RFD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Alma	Virginia	Lewis	May	1	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W		Feb 29, 1880	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Independence, Va	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Smithdeal	Emily Wilcox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	-	Mrs Mina Jessee, Bel Air RD 2 Bel Air

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic C V disease — INTERVAL BETWEEN ONSET AND DEATH: -

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ — Bel Air, Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Gerald C Palmer M.D.
Address (Street, city, town, or county)
DATE SIGNED: 5-2-61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	5/4/1961	Bel Air Memorial Gardens	Bel Air Md.

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Charles E. Kurtz Jarrettsville Md.	MAY 4 '61	Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5678

CERTIFICATE OF DEATH

Reg. Dist. No. 05666

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre De Grace
c. LENGTH OF STAY IN 1b: 1 Yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 642 N. Adams St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre De Grace
d. STREET ADDRESS: 642 N. Adams St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: J. — Last: Lewis

4. DATE OF DEATH: Month: May — Day: 18 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 20, 1885

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Locomotive Engineer.

10b. KIND OF BUSINESS OR INDUSTRY: Rail Road

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John F. Lewis

14. MOTHER'S MAIDEN NAME: Josephine Jamison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): 1903-1907

16. SOCIAL SECURITY NO.: None

INFORMANT: Ada P. Lewis, 642 N. Adams St. Havre De Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 3yrs.
DUE TO
592 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arterio Sclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19___, to May 17, 19 61 that I last saw the deceased alive on May 17, 19 61, and that death occurred at 3:15 A M, from the causes and an the date stated above.

ACTUAL SIGNATURE: Clarence I. Benson M.D. — ADDRESS (Street, city or town, state): Port Deposit, Md — DATE SIGNED: 5/19/61

PHYSICIAN'S NAME (Type): Clarence I. Benson. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-21-1961
22c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
22d. LOCATION (City, town, or county) (State): Port Deposit, Md. Rural.

23. FUNERAL DIRECTOR'S SIGNATURE: Lee a Patterson & Son
ADDRESS: Perryville, Md.
24a. REC'D BY REGISTRAR DATE: MAY 23 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5679

CERTIFICATE OF DEATH

05668

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): HAURe de GRACE
c. LENGTH OF STAY IN 1b: 7 Hrs 35 M.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAURe de GRACE
d. STREET ADDRESS: 200 S. Stokes St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARGUERITE — Middle: H. — Last: McCOMAS

4. DATE OF DEATH: Month: MAY — Day: 2 — Year: 1961

5. SEX: female — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: OCT. 26, 1906 — 9. AGE (In years, last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher — 10b. KIND OF BUSINESS OR INDUSTRY: Retired — 11. BIRTHPLACE (County & State, or foreign country): Md. — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WALTER HAINES — 14. MOTHER'S MAIDEN NAME: EMILY COALE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) — (If yes give wer or defes of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT: WILLIAM E. McCOMAS — Address: HAVRE DE GRACE, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 199X — acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b): acute cardiac Failure — 1 day
DUE TO
(c): Carcinomatosis — 4 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 56 to MAY 2, 19 61, that (I) (we) last saw the deceased alive on MAY 2 19 61, and that death occured at 12:35 M, from the causes and on the date stated above.

22a. SIGNATURE: Edward J. Simon M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 5-2-61

22c. PHYSICIAN'S NAME (Type): EDWARD J. SIMON — 22d. ADDRESS: HAVRE DE GRACE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: MAY 5, 1961 — 23c. NAME OF CEMETERY OR CREMATORY: Mountain Christian Ch. Yd. — 23d. LOCATION (City, town or county): HARFORD Co. — (State): MD.

24 FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell — ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: MAY 4 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5680 Items 8 & 9 Film G287 5/22/61 mh 05669

M

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 10 days

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 60 E Bel Air Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

3. NAME OF DECEASED (Type or print): First: Evan — Middle: M — Last: Mitchell

4. DATE OF DEATH: Month: May — Day: 7 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 29, 1914

9. AGE (In years last birthday): 46 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Canner-Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Cannery & Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Malcolm Mitchell

14. MOTHER'S MAIDEN NAME: Eva Osborn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 218-32-1619

17. INFORMANT: Lillian B. Mitchell, Address 60 E. Bel Air Ave Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 1st, 2nd, & 3rd degree burns — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): chest & upper extremities

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Taxicab caught fire

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year: 4-27 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State): Aberdeen Harford Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

Address (Street, city, town, or county): Bel Air, Md.

DATE SIGNED: 5-8-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 10, 1961

22c. NAME OF CEMETERY OR CREMATORY: Grove Cemetery

22d. LOCATION (City, town, or country) (State): Aberdeen, Maryland

23. FUNERAL DIRECTOR: John G. Tarring — ADDRESS: Tarring Funeral Home Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: MAY 12 '61

24b. REGISTRAR'S SIGNATURE: Clothus S. Krauss

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3681

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05670

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any item is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 13 days 28
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 136 Park Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: B — Last: Mitchell

4. DATE OF DEATH: Month: May — Day: 3 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-5-72

9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Josiah Bell

14. MOTHER'S MAIDEN NAME: Cornelia Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary F. Kaiser, 4212 Harcourt Rd. — Address: Balto. 14, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture L femur — INTERVAL BETWEEN ONSET AND DEATH

904.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary occlusion. Purulent pericarditis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell in her home

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year: 4-17 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Aberdeen (County) Ha. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ Bel Air Md

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 5-3-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/6/61

22c. NAME OF CEMETERY OR CREMATORY: Grove Presbyterian Cemetery, Aberdeen, Md.

22d. LOCATION (City, town, or country) (State)

23. FUNERAL DIRECTOR: John G. Tarring — ADDRESS: Tarring Funeral Home, Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: MAY 8 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Krapf

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5682

CERTIFICATE OF DEATH

05671

1. **PLACE OF DEATH**
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Harford Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen,
d. STREET ADDRESS: Chesapeake Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CHARLES — Middle: E. — Last: OLIVER

4. DATE OF DEATH: Month: May — Day: 12, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 4, 1875

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James William Oliver

14. MOTHER'S MAIDEN NAME: Sarah McCoy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: ** **

17. INFORMANT: Mrs. C.E. Oliver, Address: Aberdeen, Md. Chesapeake Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 9 day
DUE TO (b): Arterio-sclerotic Cerebro-vascular Disease with Hypertension — 4 yrs
DUE TO (c):

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept 19 to May 19 61, that (I) (we) last saw the deceased alive on May 12 19 61, and that death occured at PM, from the causes and on the date stated above.

22a. SIGNATURE: J. Ralph Horky M.D.

22b. DATE SIGNED: May 12, 1961

22c. PHYSICIAN'S NAME (Type): J.Ralph Horky, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Churchville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 15, 1961

23c. NAME OF CEMETERY OR CREMATORY: Spesutia Cemetery

23d. LOCATION (City, town or county) (State): Perryman, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — ADDRESS: Tarring Funeral Home, Aberdeen, Md.

John G. Tarring

25a. REC'D BY REGISTRAR DATE: MAY 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3683

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05672

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any information is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
d. STREET ADDRESS: R D
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Regina Middle: B. Last: Rice
4. DATE OF DEATH: Month: May Day: 11 Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 2-23-61
9. AGE (In years last birthday): yrs. 3 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hanreje Grace, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Francis Rice
14. MOTHER'S MAIDEN NAME: Betty Stehly
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Francis Rice, Address: Street, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

491X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

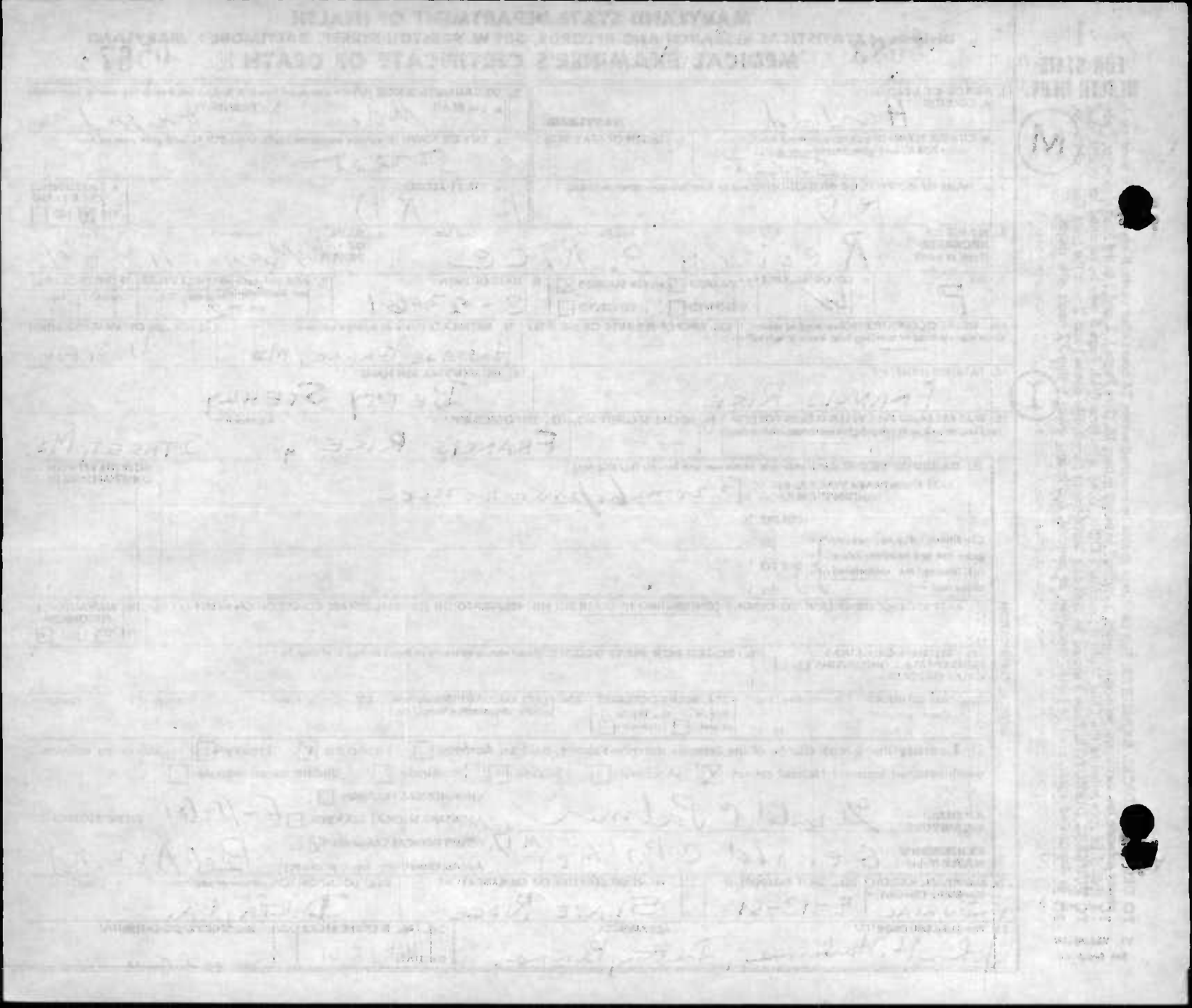
21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 5-11-61
Address (Street, city, town, or county): Bel Air Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-13-61
22c. NAME OF CEMETERY OR CREMATORY: Slate Ridge
22d. LOCATION (City, town, or country) (State): Delta, Pa.

23. FUNERAL DIRECTOR: John H. Harkins ADDRESS: Delta, Penna.
24a. REC'D BY REGISTRAR DATE: MAY 12 '61
24b. REGISTRAR'S SIGNATURE: Cinthia S Hines

VS. A15ME
5M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5684

CERTIFICATE OF DEATH

Reg. Dist. No. 05673

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 1958
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 610 Law Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen.
d. STREET ADDRESS: 610 Law Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Winnie Middle: Beatrice Last: Richards

4. DATE OF DEATH: Month: ✓ Day: 11 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/29/1880
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Nova Scotia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herman Leary
14. MOTHER'S MAIDEN NAME: Mary Jane (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 032-10-5785
17. INFORMANT: Address: Mrs Irving F. Hill - 610 Law St. Aberdeen

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): arteriosclerotic Cardiovascular disease — > 5 yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332 ✓

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-2-61, 19____, to 5-11-61, 19____, that I last saw the deceased alive on 5-2-61, 19____, and that death occurred at 10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: B J Plunkett Jr M.D.
ADDRESS (Street, city or town, state): 617 W. Bel Air Ave.
DATE SIGNED: 5-12-61
PHYSICIAN'S NAME (Type): B.J. Plunkett Jr., M.D. Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 5/12/61
22c. NAME OF CEMETERY OR CREMATORY: Cherry Valley Cemetery
22d. LOCATION (City, town, or county) (State): Cherry Valley Miss.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John G. Tarring — Tarring Funeral Home — Aberdeen, Maryland
24a. REC'D BY REGISTRAR DATE: MAY 16 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5685

CERTIFICATE OF DEATH

05674

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 1½ DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X PERRYMAN
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HAZEL — Middle: A. — Last: RICKETTS

4. DATE OF DEATH: Month: MAY — Day: 7 — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 12, 1894

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: C. Arlie Aaronson

14. MOTHER'S MAIDEN NAME: Pearl Mallick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.: ** **

17. INFORMANT: Clifford Ricketts, Perryman, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

260 X

IMMEDIATE CAUSE (a): Acidosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Anuria — 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Diabetes Mellitus (Kimmelstiel-Wilson Syndrome) — 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify, that (I) (this hospital) attended the deceased from 1948, 19..., to 5-7-, 1961, that (I) (we) last saw the deceased alive on 5-6-, 1961, and that death occured at 1.35 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Peter P. Rodman, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-8-61

22c. PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D.

22d. ADDRESS: 8 Law St., Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 9, 1961

23c. NAME OF CEMETERY OR CREMATORY: Spesutia Cemetery

23d. LOCATION (City, town or county) (State): Perryman, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John A. Tarring

Tarring Funeral Home
Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: MAY 12 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. A copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3686

CERTIFICATE OF DEATH

05675

1. **PLACE OF DEATH**
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 16½ HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR X
d. STREET ADDRESS: Box 309 R.D 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First — Middle — Last: RINE HART

4. DATE OF DEATH: Month: MAY; Day: 22; Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-21-61

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 15 / Min. 18

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): HARFORD Co. MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES RINEHART

14. MOTHER'S MAIDEN NAME: EVELYN LEONARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give wer or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address: Mr. Charles Rinehart, Bel Air Rural, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ANENCEPHALUS — INTERVAL BETWEEN ONSET AND DEATH: 15 HOURS
750X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from MAY 21, 1961, to MAY 21, 1961, that (I) (we) last saw the deceased alive on MAY 21 1961, and that death occured at 6:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Philip W. Heuman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: MAY 22, 1961

22c. PHYSICIAN'S NAME (Type): PHILIP W. HEUMAN M.D

22d. ADDRESS: 307 HICKORY, BEL AIR, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: MAY 23, 1961

23c. NAME OF CEMETERY OR CREMATORY: St. Ignatius Cemetery

23d. LOCATION (City, town or county) (State): Hickory, Harford Co., Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland

25a. REC'D BY REGISTRAR DATE: MAY 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2071296 XYY

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5687 **CERTIFICATE OF DEATH** 05676

1. **PLACE OF DEATH**
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 634 Colaine Drive

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 634 Colaine Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle — Last SCARLATA

4. DATE OF DEATH: Month May — Day 31 — Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 15, 1890

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber, (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Barber

11. BIRTHPLACE (County & State, or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give were or dates of service): 057-28-9110

17. INFORMANT: 634 Colaine Drive Mary Phillips, Aberdeen, Maryland

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Abdominal Carcinomatosis
DUE TO (b):
DUE TO (c):
199X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: ~ 4 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-12-61, 19__ to 5-31-, 1961, that (I) (~~We~~) last saw the deceased alive on 5-31-1961, and that death occured at 7:45 PM from the causes and on the date stated above.

22a. SIGNATURE: B.J. Plumkett Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-1-61

22c. PHYSICIAN'S NAME (Type): B.J. Plumkett Jr. M.D.

22d. ADDRESS: 617 W. Bel Air Ave, Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Rempval

23b. DATE THEREOF: 6/1/61

23c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery

23d. LOCATION (City, town or county) (State): Poughkeepsie, New York

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — Tarring Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: JUN 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5688

CERTIFICATE OF DEATH

05677

1. **PLACE OF DEATH**
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural -Street
c. LENGTH OF STAY IN 1b: 61 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Street
d. STREET ADDRESS: Grier Nursery Rd.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: EDWARD — Middle: W. — Last: STEWART

4. **DATE OF DEATH**: Month: May — Day: 2, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: May 31, 1899

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto mechanic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Street, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James W. Stewart

14. MOTHER'S MAIDEN NAME: Lillis D. Iley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-22-3099

17. INFORMANT: Mrs. Edward W. Stewart, Address: Street, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): [illegible]
DUE TO (b): Cerebrovascular Accident
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH
(a) [illegible]
(b) 12 years
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1957, 19..., to May 2, 19 61, that (I) (we) last saw the deceased alive on May 1 19 61, and that death occured at 10 AM, from the causes and on the date stated above.

22e. SIGNATURE: [signature] M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 5-5-61

22c. PHYSICIAN'S NAME (Type): Benj. Dorogi

22d. ADDRESS: Cardiff, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 5,1961

23c. NAME OF CEMETERY OR CREMATORY: Highland

23d. LOCATION (City, town or county) (State): Street, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John H. Harbine

ADDRESS: Delta, Pa.

25a. REC'D BY REGISTRAR DATE: MAY 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5688 — 05678

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Havre de Grace
d. STREET ADDRESS: 418 N Stokes St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Earle — Middle: M. — Last: Stirling
4. DATE OF DEATH: Month: May — Day: 18 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 31 - 1890
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert Stirling
14. MOTHER'S MAIDEN NAME: Hannah (Smith) Stirling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): Unknown
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Chas A. Stirling — Address: 418 N. Stokes Havre de Grace Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, left upper lobe — INTERVAL BETWEEN ONSET AND DEATH: 10 days.
491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary tuberculosis with cavities, left
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐ OBX

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/8/61 19..., to 5/18..., 1961, that (I) (~~saw~~) last saw the deceased alive on 5/18 ...1961, and that death occured at 10 AM, from the causes and on the date stated above.

22a. SIGNATURE: Edward E. Loo M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/19/61
22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): 23b. DATE THEREOF: 5/21/61
23c. NAME OF CEMETERY OR CREMATORY: Angel Hill
23d. LOCATION (City, town or county) (State): Harvre de Grace, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son, Harvre de Grace, Md — ADDRESS
25a. REC'D BY REGISTRAR: DATE MAY 23 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5690

CERTIFICATE OF DEATH

05679

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XXXXXXXXXX Bel Air
d. STREET ADDRESS: Rt # 2 Box 164
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Franklin — Last: Supik

4. DATE OF DEATH: Month: 5 — Day: 16 — Year: 1961

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 16, 1881

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & Blacksmith (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Farm & Shop

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Supik

14. MOTHER'S MAIDEN NAME: Carrie Supik (Sdec)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215-22-6951

17. INFORMANT: John F. Supik Jr., RD 2, Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure & Arteriosclerotic Heart Disease
DUE TO (b): Pulmonary Edema
DUE TO (c): Chronic Lung Disease (Emphysema)
527.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute Suppurative Cholecystitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/9/61, 19, to 5-16, 19 61, that (I) (we) last saw the deceased alive on 19, and that death occured at 2 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Frank D. Hauber M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-17-61

22c. PHYSICIAN'S NAME (Type): Frank D. Hauber, M.D.

22d. ADDRESS: 610 S. Union Ave, Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 19, 1961

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens,

23d. LOCATION (City, town or county) (State): Bel Air, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring

ADDRESS: Tarring Funeral Home, Aberdeen, Md.

John G. Tarring

25a. REC'D BY REGISTRAR DATE: MAY 22 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5691

CERTIFICATE OF DEATH

05680

1. **PLACE OF DEATH**
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: Chapel Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Louise — Middle: — Last: Thompson

4. **DATE OF DEATH**: Month: May — Day: 24 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 4, 1895

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Yeager

14. MOTHER'S MAIDEN NAME: Ida (Shavell) Yeager

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 1- Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): 2- A.S.C.V.D. and H.C.V.D. — 7 years

DUE TO (c):

491 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus ② Chronic Cholecystitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 19th 1961 to May 24th 1961, that (I) ~~(we)~~ last saw the deceased alive on May 24th 1961, and that death occured at 12:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/24/61

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/28/61

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town or county) (State): R.D. Bel Air, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John T. Tarring — ADDRESS: Tarring Funeral Home Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: JUN 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. A fee may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5692

Reg. Dist. No. 5681

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Magnolia
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Magnolia
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Clinton; Middle: Alexander; Last: Turner

4. DATE OF DEATH: Month: May; Day: 3; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 27, 1894

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Locomotive Operator

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Turner

14. MOTHER'S MAIDEN NAME: Alice Stauffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-20-7020

17. INFORMANT: Mrs. Clinton Turner — Address: Magnolia, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Gastrointestinal Hemorrhage.
420.1
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month / Day / Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/26, 19__, to 5/3, 1961, that I last saw the deceased alive on 4/26, 1961, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Louis Kahan M.D.
ADDRESS (Street, City or Town, state): Box 966 Edgewood
DATE SIGNED: 5/3/61

PHYSICIAN'S NAME (Type): E. Louis Kahan
Edgewood, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 6, 1961
22c. NAME OF CEMETERY OR CREMATORY: Cokesbury Memorial
22d. LOCATION (City, town, or county) (State): Abingdon, Harford Md

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. McComas & Son
ADDRESS: Abingdon, Md.

24a. REC'D BY REGISTRAR DATE: MAY 8 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5693

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05682

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun Rural
d. STREET ADDRESS: [illegible] 07X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Gregor	Yolen W.	Wilson	May	12	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W		12-16-1915	45 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	Const. Co.	West Virginia	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Abe Wilson	Bine Holcomb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
yes WWII	234205871	Mrs. Stella Wilson	Rising Sun, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture skull — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Crushing injury chest. Fracture R humerus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Auto accident

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
4	5-17-1961				Cecil	Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ Bel Air, Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)
DATE SIGNED: 5-12-61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country)	(State)
Burial	5-16-1961	Mingo Cem.	Mingo	West Virg.

23. FUNERAL DIRECTOR	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Vernon E. McMullen	Rising Sun, Md.	MAY 16 '61	Arthur S. Krauss